Walgreens HEALTH INITIATIVES

Rev. 02/19/99

Member Prescription Reimbursement Claim Form

Use this claim form to seek reimbursement for prescriptions obtained at a non-participating pharmacy.
Incomplete information may delay processing or may cause form to be returned to member.
Please submit one form for each individual patient.

Completed DMR forms (with receipts) must be submitted within 180 days in order to be reimbursed.

MEMBER SECTION

Client Name: Keys Physician-Hospital Alliance Client Number: 6010

Member Name: _____ Soc. Sec. Number: _____ - ____ - _____

Member Address: _____

City: _____ St: _____ Zip: _____ - _____

Patient Name: _____ (if other than member)

Relationship: ____ 02=spouse ___ 03=dependent (if other than member)

Birth Date: _____ - _____ - _____ Sex: ___ Male ____ Female

Patient ID: _____ (11 digit ID - copy exactly from WHP ID card)

Request Reason (i.e. traveling, etc.): _____

PHARMACY SECTION

(If you need assistance in filling out necessary information, please refer to your receipt or contact the pharmacy in which the medication was dispensed.)

Fill Date	Pharmacy NABP (7 digits)	Rx #	Drug NDC# 11 digits	Qty	Days Supply	DAW paycode	Total Paid

I certify the prescription(s) referred to above have been received and information stated is accurate. I also authorize the release of all information contained herein to Walgreens Health Initiatives and its agents.

Participant's Signature: _____ Date: _____

Mail to:
Walgreens Health Initiatives
2275 Half Day Road, Suite 250
Bannockburn, IL 60015

Don't forget to attach the original prescription receipt and the cash register receipt to this form.

Reimbursement is based on your Plan's maximum benefit.

Questions concerning this form, call 1-800-207-2568